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THE RHODE ISLAND MEDICAL JOURNAL

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THE CARE OF THE PATIENT WITH PEPTIC ULCER

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The therapy of peptic ulcer divides itself into three categories:

1. Treatment of the local condition.
2. Treatment of the patient's general health, and
3. Education of the patient concerning the nature of his disease.

The physician's success with ulcer patients depends upon giving adequate attention to all three of these points. It has not been sufficiently emphasized that the best kind of local treatment will achieve only temporary relief if the other two are neglected. Every patient requires the same attention concerning his general health and an intelligent understanding of the nature of his disease; whereas, the local treatment will vary, depending upon the conditions which each patient presents.

The first problem is to decide which of the many available treatments to use for the individual patient. Unfortunately most of the literature on the subject serves to confuse rather than assist the physician in his choice. This is because too many articles have been written in which conclusions are drawn from too small a series of cases and over an inadequate period of observation. Enthusiasm for a new method and a desire to be up-to-date are responsible for many papers which might never be published if a longer time was taken for observing the results, or for studying more cases.

For years, peptic ulcer was believed to be a curable disease. However, in 1926, Dr. Monroe and I began an intensive study of the patients which we had observed in the Peter Bent Brigham Hospital, the results of which we published in 1929. At this time we wrote, "All evidence points to the fact that ulcer is a chronic disease and that all the

present methods of treatment are merely palliative. Cure probably is rare. Each method of treatment has its advantages and disadvantages which must be weighed in the individual case. The best results are to be expected from a wise choice of these methods; the education of the patient concerning the nature of his condition and the amount of relief that can be expected." This was considered a radical statement at the time it was published, but today it is generally accepted.

By 1935 we were able to report from an equally intensive study on 1435 patients that, "It is demonstrated that none of the present methods of treatment do more than assist in the induction of remissions, no matter how strict the medical schedule or how radical the operation. Surgical procedures produce longer periods of freedom from symptoms than medical treatment, but the former also carry a definite threat to life and often produce mechanical situations which make subsequent attacks difficult to control." In other words, the situation had not materially changed in the ten years during which we had been closely following this disease. Meanwhile, such enthusiastic surgical reports had been accumulating in the American literature concerning the value of gastric resections, that it seemed wise to inject a note of caution. In 1934 I wrote, "It can be easily demonstrated that control of the acidity throughout the day is not sufficient for healing, if a continuous secretion occurs at night. If an operation is performed where this condition is present and the mucous membrane of the jejunum is forced to come into contact with the gastric acidity daily from 18 to 24 hours, it is unlikely that the resistance of the membrane will be sufficient to prevent the development of an ulcer. Therefore, one should not advocate surgery in the presence of a continuous secretion." This statement was made when many clinics were advocating partial resections of the stomach. Since then it

From the Medical Clinic of the Peter Bent Brigham Hospital, Department of Medicine, Harvard Medical School.

Given in part before the Cambridge Medical Improvement Society.

has become evident that only the most extensive resection will give any assurance of permanent relief for patients with a hyper-secretion. During more recent years nothing has occurred to change any of the statements which I have made in the past. Although many of my views were not popular at that time, I have had the satisfaction of living long enough to see them generally accepted. However, there is still a strong tendency to treat the disease as if it were a curable one.

By now, we have had experience from approximately 3000 cases, from which I would first point out that the great majority of these patients can be satisfactorily treated by the general practitioner. Only a relatively small number of our patients applying to the hospital are sent to the wards. The rest are being adequately cared for in the Out-Patient Department by methods which are available to any physician. Because most of these individuals are in an economic status which leads them to utilize the hospital, it is obvious that the patient consulting a private physician is better able to care for himself than many of the individuals whom we are treating.

The choice of local treatment should be guided by the severity of the disease. I should like to emphasize this point to which little attention has been given, although physicians are accustomed to take this factor into consideration with other diseases. A patient with a mild hypertrophic arthritis of the knee is not given the same intensive treatment as a severe general arthritic. A mild diabetic is treated much more simply than a severe one. Yet, the profession has been prone to standardize the treatment for peptic ulcer without regard to the severity of the disease in a given individual. Yet, peptic ulcer varies in the severity of its manifestations fully as much as arthritis or diabetes. Therefore, our first objective is to evaluate the severity of the individual case. Although one cannot accurately classify every patient, it is possible to recognize many of the severe cases and many of the mild ones. I have learned to recognize types of patients who are always resistant to treatment. They have a severe grade of pain and frequently suffer from distress in the middle of the night. They show an unstable autonomic nervous system as manifested by a moist skin, particularly of the palms and they flush easily. They often exhibit the typical ulcer diathesis, or the lean and hungry look of Cassius. These individuals usually have a slight

build and thin features with a pointed chin. They are often underweight and report an inability to gain weight. The very severe case suffers from a hypersecretion as determined by gastric analysis. In this regard, we are interested in the amount of secretion rather than in the titratable acidity, a high acid being of less significance than a high acid combined with a large volume. Therefore, the thin, highly nervous patient who is having frequent and severe pain, particularly at night and who is found to have a hypersecretion, falls into the severe class.

On the other hand, the mild case has less pain and he is less subject to distress at night. The periods of freedom from symptoms tend to be longer than in the severe case and a hypersecretion does not occur. He is more likely to have a normal weight and a normal nervous system. This group can usually be recognized easily. The need for evaluating the severity of the disease is obvious because it is not necessary to treat a mild case by a radical form of therapy; and conversely, it is ineffective to treat a severe case by an inadequate therapy.

The objectives of local treatment are to promote healing by minimizing those factors which interfere with healing and to relieve discomfort. The value of bland diets, which were originally prescribed empirically, has been demonstrated experimentally by Ivy and clinically by Soper, so that their use is indicated provided that the diet is well balanced as regards protein, carbohydrate and fat and contains sufficient calories and vitamins. Frequent feedings serve to relieve discomfort as do small doses of alkalis.

Antispasmodics may be useful particularly in the presence of a pylorospasm and atropin should be prescribed to the point of tolerance.

In addition to the above measures, complete neutralization of the gastric acidity may be undertaken by means of the Sippy regime. The profession continues to disagree on the value of complete neutralization because of what appears to be conflicting observations on the relationship of hydrochloric acid to peptic ulcer. The evidence for such a relationship comes from clinical observation and the laboratory. It is known that peptic ulcers occur only in regions bathed by hydrochloric acid. In addition to the stomach and first portion of the duodenum, these ulcers are found in the esophagus and a Meckel's diverticulum provided secreting

aberrant gastric tissue is present. Using the technique originally devised by Williamson and Mann, laboratory workers have demonstrated that true peptic ulcers develop in the presence of a gastric acidity but do not occur if the hydrochloric acid is neutralized or diverted. This evidence favors overwhelmingly some relationship between hydrochloric acid and a peptic ulcer.

However, it has been proved that peptic ulcers heal spontaneously although the gastric acidity does not change. Therefore, although the acidity is not the cause of an ulcer, apparently it assists in its development and may serve to retard healing of the local lesion when the disease enters a quiescent phase. Although control of the acidity is not essential, it would seem to be beneficial, particularly in the more resistant cases. My experience indicates that this is true.

The use of the Sippy regime would be indicated for most patients if it were not for certain disadvantages. It is troublesome and virtually requires hospitalization if it is to be successful. Partial neutralization may be sufficient to relieve symptoms but unless complete or nearly complete neutralization is established, the regime does not promote healing. The quick relief of symptoms leads patients into the erroneous belief that the ulcer is healing with a consequent disregard for attention to the general hygienic measures without which any treatment is inadequate. Therefore, unless complete neutralization is established and unless the other therapeutic procedures which we will discuss in a moment are thoroughly carried out, it is better not to instigate the Sippy regime.

The last form of local treatment is surgery which accomplishes its purpose by diverting the hydrochloric acid and removing ulcer-bearing areas.

Now we come to the treatment of the general health and it should be emphasized that no available local therapy whether medical or surgical can be sure of success if the general treatment of the patient is neglected. We base our general treatment on eliminating those factors which are known to accompany reactivity of an ulcer. These are:—

- a. Emotional and nervous tension.
- b. Infection.
- c. General debility and fatigue.

No treatment can be considered adequate nor can the physician hope for satisfactory results if the three factors of nervous tension, infection and fatigue are neglected. It is not uncommon to en-

counter antagonism when this subject is first broached, but when the patient realizes that our restrictions do not interfere with his business life, but will make him a more effective individual, he will usually cooperate. Observation reveals that most patients expend an extraordinary amount of useless energy through failure to plan their activities. Caution the patient against undue haste and nervous tension. Advise a sufficient amount of time for dressing, eating breakfast, etc. so that he or she can get to his place of business without any sense of pressure. Stress the value of short periods of relaxation throughout the day. The army knows that it can march a body of men farther and more efficiently if a five-minute rest period is allowed every hour. What is true for the muscular system is also true for the nervous system. Meal time should be one of relaxation rather than tension and rapid eating. Rapid automobile driving produces an expenditure of nervous energy entirely out of proportion to the few minutes it may possibly save and should be frowned upon. Outline a daily program for the patient which will assist him in living a more desirable existence.

The debilitating effect of infection should be explained and the need for preventing upper respiratory infections should be emphasized. It should be pointed out that a certain amount of nervous tension alone, or an ordinary infection alone, may not be sufficient to lower the patient's resistance to the point of reactivating the ulcer; whereas, a combination of the two may be enough to bring a return of symptoms. The prevention of general fatigue by well-timed vacations when they can be taken, an adequate amount of sleep which for most of these patients is a minimum of nine hours and a period of rest in the middle of the day when it is possible to obtain it, will serve to mitigate the development of fatigue.

This seems to be as good a time as any to discuss the matter of smoking and drinking. There can be no question that tobacco and alcohol are contraindicated theoretically and to some extent from clinical experience. Practically, is it better to forbid the use of these substances or allow them in moderation? I have found it difficult to get patients to forego these pleasures for the rest of their lives and because I have been unable to demonstrate that their use in moderation does any harm. I advise total abstinence only while the ulcer is active. After healing has occurred the patient is permitted

10 cigarettes a day or their equivalent. No alcohol is to be taken on an empty stomach, but a weak drink may occasionally be consumed during or after a meal. These rules do not deprive the patient of some social pleasures which in my experience they are more prone to follow than if they are forbidden to ever indulge.

This period of education can go on concomitantly with advice about diet and other medicinal procedures until such time as the ulcer has healed and the patient is free of symptoms. The patient should be encouraged to return at periodic intervals in order that the physician's influence will continue to be exerted toward a sound regimen.

Now having discussed the various methods of treatment at our disposal, how are we going to apply them to the individual case?

Mild cases will do well on almost any good regime and can be ambulatory from the beginning. Being mild, the ulcers heal more rapidly and the distress is easy to control during the active phase. During the active period the patient will receive three meals of bland food with milk once between meals and alkali 3-5 times a day to relieve symptoms. These measures will be adequate if the general treatment is carefully followed out. After healing has occurred, a normal diet should be given but the general treatment must continue.

The moderately severe cases require more intensive treatment. A period of bedrest is indicated, preferably a minimum of three weeks. If the patient is unduly restless or nervous some sedation should be prescribed. Whether to use the Sippy regime depends upon circumstances. Each physician must decide this by his available opportunities for accurately carrying out the regime and by the social and economic status of his patient. However, let me repeat that relief without complete neutralization of the gastric juice has the above-mentioned disadvantage of misleading the patient concerning the behavior of the ulcer and is accomplishing nothing useful toward healing the lesion. To obtain complete neutralization with the Sippy regime virtually requires hospitalization and is a tricky business at best so that I am inclined to believe that the general practitioner will do better to forego its use in the moderately severe case.

In caring for the severe case, the use of modern surgery would seem to be indicated for most individuals, in whom the tendency to recurrence is quite marked and for whom a recurrence is usually a

serious matter because of the severity of the distress. It is usually impossible to make the individual comfortable while he is carrying on his daily routine. Therefore, these patients are forced to temporarily give up their work for a period of rest and this is impossible for a large group of the population. Moreover, the danger of perforation is somewhat greater, as well as the danger of massive bleeding. However, it must be realized that if surgery is contemplated it should be of a radical sort. The simpler operations such as a Billroth I, gastroenterostomy and small resections of the antrum are insufficient to prevent a recurrence in the large majority of the very severe cases. It is much better to remove as much of the stomach as possible, making a large anastomosis, according to the method of Polya. This decreases to a large degree, the volume of hydrochloric acid which can be excreted and the large stoma serves to dilute whatever hydrochloric acid is ultimately secreted. The operation has the further advantage that it removes a large portion of the ulcer-bearing area. Yet, in spite of these very radical procedures we have had patients in whom a marginal ulcer developed. There is also another objection to this operation because some patients are bothered by a feeling of weakness and distress after meals which apparently is associated in some way with the rapid entry of food into the small intestine. We are now using a fundusectomy which more effectively removes the acid-secreting portion of the stomach and yet permits a small amount of stomach to remain; thereby tending to overcome the disadvantage of having the food enter the small intestine so rapidly. We have had a number of patients operated upon this way and the results to date have been very satisfactory. If there is a contraindication to surgery in these patients, we are forced to utilize medical treatment. It has been my experience that these patients do badly because of the large volume of acid which they secrete. The ordinary soluble alkalis such as bicarbonate of soda are unsatisfactory because their administration increases the secretion of hydrochloric acid. The patient is very likely to develop severe alkalosis, so that adequate neutralization of the gastric juices is interfered with. Largely because of this reason, numerous other types of antacids have been developed and advocated.

Of all the new drugs, colloidal aluminum hydroxide has proven to be the most satisfactory because it will not only adequately neutralize the gastric

secretion if given in large enough amounts, but also inhibits the secretion of hydrochloric acid, presumably by its astringent effect. In order to obtain this latter effect, we have found it better to keep the stomach bathed with the drug, 24 hours out of the 24 for a period of at least a week. This may be done by allowing material to drip continuously into the stomach through a nasal catheter, or by having the patient awakened at hourly intervals throughout the night to take the medicine by mouth. It requires three weeks to accomplish the same results if the drug is given only during the day. This sort of treatment requires hospitalization. Many of the patients object to having the nasal tube continuously and the apparatus has to be watched closely to prevent interruption in the flow of the material. Following a week to ten days of this treatment, the tube can be removed and the patient given the substance at hourly intervals throughout the day until nine o'clock in the evening. As time goes on, the amount of aluminum hydroxide can be gradually decreased, but a certain amount will have to be taken in order to prevent the reestablishment of a high secretion. This raises the question of how long the more severe cases should receive bedrest and how long they should receive intensive antacid therapy.

It seems to me that it is foolish to allow a patient to become active and go back to work before his ulcer is healed when we are dealing with the severe type of the disease. If the ulcer does not heal under the best possible conditions, it seems unlikely that it is going to heal under a less satisfactory situation. Hence, it is my rule to keep the patient in bed or in a semi-active state until the ulcer has healed, as shown by: absence of symptoms, the disappearance of occult blood from the stool and the disappearance of a crater as judged by the x-ray. Having once healed, how long should the antacid therapy be continued after healing has taken place? This is a matter on which we have no definite criteria to base a decision. Sippy originally kept his patients on treatment for a month and later increased it to three months with a definite decrease in the rapidity with which recurrences developed. A further increase of six months gave more satisfactory results and he finally urged his patients to remain on the treatment for a year. Brown, from a study of Sippy's former patients has reported the best medical results which may depend upon the long continued antacid therapy. With our present knowledge

of the disease, it would seem as though a year was unnecessarily long. On the other hand, two authors have reported that it takes three months for a knife cut in the duodenum to heal completely, as judged histologically. If this is true of a simple, clean incision it would seem as though a similar length of time would be required for thorough healing of an ulcerous lesion. Therefore, I have set three months as an arbitrary time for keeping patients on an antacid regime. The regime is then modified until ultimately the patient is down to five meals a day with as much aluminum hydroxide as is necessary to restrict the secretion of hydrochloric acid.

I have discussed in some detail the treatment of the mild and the most severe case, both of which can usually be recognized fairly easily. Between these two extremes, fall a large number of patients who will be rated as "moderately severe" but their response to treatment cannot be accurately determined beforehand. The therapy for these patients will have to vary between the two extremes which I have already given, but the essential principles remain the same.

In conclusion, the treatment of peptic ulcer is divided into those measures which affect the local conditions and those measures which benefit or control the general health of the patient. The type of local treatment will vary with the severity of the disease in the particular patient under consideration. The choice of local treatments consist of bland diets with frequent feedings, the object of which is to relieve distress, complete neutralization of the gastric acidity and surgery. Ultimate success in the treatment of this disease demands that every patient shall be educated regarding the nature of his disease and receive careful instructions concerning his general health, particularly as to nervous tension, infection and fatigue.

A COLLEAGUE'S PATIENT

When a physician is requested by a colleague to care for a patient during his temporary absence, or when, because of an emergency, he is asked to see a patient of a colleague, the physician should treat the patient in the same manner and with the same delicacy as he would have one of his own patients cared for under similar circumstances. The patient should be returned to the care of the attending physician as soon as possible.

From the Code of Ethics of the A. M. A.

USHER PARSONS
A FOUNDER OF
THE RHODE ISLAND HOSPITAL

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At a regular meeting of the Providence Medical Association held on October 6, 1851, the President, Dr. Usher Parsons, presented for consideration the subject of a general hospital in Providence. The matter was referred to a committee of seven: Dr. Usher Parsons, Chairman, and Drs. Joseph Mauran, Lewis L. Miller, Richmond Brownell, George Capron, S. Augustus Arnold, and Charles W. Fabyan. This committee reported at the November meeting, recommending that a circular be prepared and presented to the citizens, setting forth "the amount of suffering and destitution that called loudly for hospital relief. This circular was distributed widely but awakened little or no interest in the desired object." The year following, a subscription paper was prepared and was presented to some of the leading citizens, "but the project failed, no one seeming inclined to head the list." Dr. Parsons next drafted a petition to the Providence City Government, "asking its aid and cooperation in devising some measures for relief." In the petition he recommended that a hospital be provided by the city, to be sustained by private subscription, and suggested that the Tockwotton Estate, then occupied by the Reform School, be converted to the use of a hospital. He prayed that this or some other suitable place be appropriated for a hospital, on condition that the sum of fifty thousand dollars be raised by subscription for defraying current expenses. This petition received respectful attention from the Providence City Council and a committee was appointed to confer with the committee from the medical association. These committees disagreed on the location to be provided. In South Providence, for three quarters of a century, a long, low, two-story building had stood on the crest of an elevation just west of Eddy Street. It was known as the Marine Hospital and was used by the city for contagious diseases, especially ship fever and small-pox. The committees were unable to agree on either the Tockwotton Estate or the Marine Hospital lot; furthermore the fifty thousand dollars was not subscribed; the whole project lay dormant for ten years.

Read before a meeting of the Providence Medical History Club, March 26, 1940.

In the meantime, Thomas Poynton Ives, son of a wealthy and philanthropic citizen of Providence, undertook the study of medicine, registered with Dr. J. W. C. Ely as preceptor, and attended medical lectures at the College of Physicians and Surgeons in New York. On the outbreak of the Civil War, Thomas P. Ives gave to the government his yacht, received a commission as lieutenant-commander in the Navy, and served throughout the war. Late in 1862, while home on a furlough, he called upon Dr. Parsons with a petition to the Rhode Island Legislature which he had prepared and wished to have signed by the members of the committee of the medical association. The petition requested an act of incorporation for a Rhode Island Hospital. Mr. Ives' father had made in his will a bequest of forty thousand dollars to a hospital whenever it should be built in Providence; to this amount Mr. Ives proposed himself to add ten thousand dollars.

The legislature granted the charter, the City of Providence donated the Marine Hospital site, a subscription amounting to \$380,000 was obtained. The success of the project for which Dr. Parsons had worked so long and so diligently was assured. He was then seventy-five years old.

Usher Parsons was born in Alfred, Maine, in 1788. His name, Usher, was the family name of his grandmother, without known connection with that "House of Usher" whose fall was chronicled by Poe. After attending the village school and the Academy at Berwick, Parsons entered the office of Dr. Hall of Alfred as a student of medicine and attended a course of lectures on anatomy given at Fryeburg. Three years later, in 1811, he came to Boston for study with Dr. John Warren and on February 7th of the following year, was licensed as a Practitioner of Medicine by the Massachusetts Medical Society.

On June 19, 1812, President Madison declared war with Great Britain. On July 6th, Usher Parsons received a commission as surgeon's mate in the United States Navy. He was stationed first at Salem, Mass., later at Black Rock, just north of Buffalo on the Niagara River, where he was in charge of the station for care of the sick and wounded. In March, 1813, Captain Oliver Hazard

Perry arrived from Newport, Rhode Island, to superintend outfitting of a fleet to contend with the British squadron for control of Lake Erie. He transferred the Black Rock station to Erie, Pennsylvania, where the new Court House was converted to hospital use. The surgical staff included two other surgeons beside Usher Parsons.

The British had six vessels carrying sixty-three guns. Perry got together nine vessels with fifty-four guns and gave battle to the British at Put-in-Bay on September 10th. Perry's flagship, the *Lawrence*, was soon ruined; not a gun could be fired, the masts were torn away, many sailors killed. Perry seized his banner with the motto, "Don't Give Up the Ship," took off in a small boat, and transferred his flag to the uninjured *Niagara*. He charged the enemy and drove through the midst of the hostile squadron, discharging broadsides right and left. In fifteen minutes the battle was over and Perry controlled Lake Erie. He sent to General Harrison his famous message, "We have met the enemy and they are ours." Since that time the battle of Lake Erie has been commemorated on the face of all authentic banjo clocks.

At the time of the battle, many of the officers and their crews were prostrated with bilious fever. The two other surgeons were incapacitated for work but Dr. Parsons had recovered from his attack. The entire task of caring for the sick and wounded fell on him. During the battle he amputated six legs; during the following night he dressed about a third of the wounded and controlled the hemorrhage of the others with tourniquets. The following days he was assisted by the British surgeons.

After the close of the war, Parsons accompanied Perry on the frigate *Java* to the Mediterranean, to care for American interests in the Barbary States. The cruise lasted for two years and finished at Newport in March, 1817. In July, Parsons visited Providence with an idea that he might settle there but instead took a course of lectures at Harvard Medical School and received the degree of M.D. in the year 1818. Next he sailed from Boston on the frigate *Guerriere* for a cruise which took him to St. Petersburg and then to the Mediterranean. Leaving the ship at Naples, he made a tour of Italy, France and England, studying and visiting hospitals at Palermo, Messina, Florence, Genoa, Nice, Paris and London.

During these years abroad he added to the large circle of acquaintances which he had made while

on active service in the Navy. He knew intimately Dupuytren, Boyer, Allbert, Larrey, DuBois, Pinel, GayLussac, Abernethy, Astley Cooper, and Sir Humphrey Davy.

In 1820, Parsons returned to Boston, where he was stationed at the Marine Barracks at Charlestown. In August of this year, he accepted the chair of Anatomy and Surgery at Dartmouth and in April of the following year he came to Providence as Professor of Anatomy and Surgery at Brown University. In 1822, he was married. His wife lived only two years but left him a son, Charles W. Parsons, who became an eminent physician in Providence. Usher Parsons lived first on Benefit Street, opposite St. John's Rectory, later at 13 President Street, now Waterman Street. He did an active medical and surgical practice. He successfully performed operations for hernia, enucleation of the eyeball, frequent operations for cataract. To his credit it is reported that he did the popular operation of the day, lithotomy, only once. His anesthetics were for the most part, laudanum and brandy.

He wrote many (58) articles on medical topics and on biographical, historical, and other subjects. He won the Boylston prize three times and wrote the Fiske Fund Prize Dissertation on "Spinal Diseases."

Usher Parsons was President of the Rhode Island Medical Society for three terms, 1837-1840. In 1847, as delegate from the Rhode Island Society, he was present at the founding of the American Medical Association. In 1854 he was Vice President of the American Medical Association and served as Acting President in the absence of the President. In 1851 he was elected President of the Providence Medical Association. In this year he began the mission which resulted in the founding of the Rhode Island Hospital.

Twelve years later, in March, 1863, the names of twelve eminent physicians were read in the old State House on Benefit Street: "It is enacted by the General Assembly as follows:—Usher Parsons, Joseph Mauran, Lewis L. Miller, Richmond Brownell, Samuel Boyd Tobey, George Capron, S. A. Arnold, Hervey Armington, C. W. Fabyan, George L. Collins, J. W. C. Ely, W. Owen Brown, and their associates, who may hereafter be admitted members of the Corporation hereinafter created, according to the By-laws thereof, are incorporated and made a body corporate and politic by the name and style of the Rhode Island Hospital."

For Usher Parsons, the founding of the corporation began the fulfilment of a long cherished dream. Now, with the aid of Captain Ives, plans for construction of the hospital buildings went forward rapidly. The Marine Hospital site, donated by the City of Providence, comprised about twelve acres of land. Eight friends of the hospital, led by Captain Ives, purchased additional land to the west of the Marine Hospital plat, making the entire lot sixteen and a third acres. The location was ideal for its purpose, a mile from the civic center, readily accessible. At the center of the lot the land was seventy feet above water level, sloping gradually from this height to the bay. At the south-east corner was a pond of clear water which had been fed by a stream which crossed Broad Street at Comstock Avenue. It seemed that, as the bed of this stream had been filled in, its waters found their way to the original outlet by underground passages. In grading the hospital plat, the crest of the hill was lowered fifteen feet, leaving a flat plateau for the foundation of the buildings.

Many years later, the Superintendent of the Rhode Island Hospital would state in his annual report:—"The founders of this place built on broad lines in selecting a site large enough in the beginning, within easy access of the center of the city, and with buildings that are marvels of good construction and good taste. It is remarkable how well thought out and how well planned was this building erected forty-five years ago. The site, the ventilation, the light, the arrangement of floor space, the construction, the attention paid to details, in fact the practicability of the whole scheme, the broad foundation on which the whole plant was built, the foresight as to future developments as shown in the original plans of 1865, the wisdom of securing a great area of land about the buildings, the broad and wise financial foundation, are all unusual. The more I see and know of institutional work, the more do I appreciate and admire the wisdom and the forethought of the founders of this great hospital."

Preparation of plans for the hospital was entrusted to Alpheus C. Morse, a twenty-seven year old Providence architect who had studied with Alexander Parrish in Boston and later with Washington Allston in Rome. A follower of John Ruskin, he had studied the architecture of Modena, Pavia, Mantua and Verona. There he became a master of the Italian Gothic style, commended by

Ruskin "not merely because it is lovely, but because it is the only form of faithful, strong, enduring, and honorable building, in such materials as come daily to our hands." The task given to Morse by the building committee was to prepare "buildings which should be in every way practical for the work of a hospital, adequately ventilated, heated and lighted; with solid foundations, stairways of stone, fireproof; with a sufficient supply of fresh water to be stored in water towers; a plant capable of expansion to meet the demands of future growth; and withal, buildings in harmony with their setting and not lacking in the element of beauty."

Morse solved the problem with plans for a central or administration building with pavillions or wings, the administration building of sufficient size to provide for the needs of generations to come, the pavillion plan allowing for expansion to an indefinite limit by the simple addition of other wings essentially similar to those first constructed. On massive foundations he built brick walls of great thickness, enclosing an air space to protect the interior against changes of temperature; the roof gabled, with a sufficient number of superimposed pinnacles to answer the requirements of a pure Gothic style. The difficult water problem he solved by building two towers, each with a capacity of 4,000 gallons. Just in back of the north pavillion was a cistern of 80,000 gallons capacity which collected rain water from the roof. Fresh water was obtained from a well sunk to the west of the pond. Pure, fresh air, heated by being passed over steam pipes in brick chambers in the basement, was conveyed through brick passages to the various wards and rooms. Within the walls of the hospital, channels a foot square, of cement as hard and polished as glass, provided a perfect system of ventilation. The ventilating channels united in the attic where huge pipes conducted the air to a central exit in the roof. The hospital was lighted with gas. The sewers discharged into a cesspool.

Usher Parsons was seventy-five years old when work was started on the Rhode Island Hospital. That year, because of his failing physical and mental health, he withdrew from active practice. He enjoyed reading, frequented the Athenaeum, and interested himself in watching the progress of the work at the hospital. On November 17, 1865, the hospital project received a severe set-back through the death of Captain Thomas Poynton Ives, who died at the age of thirty-three as a result of injuries

suffered during his service in the Civil War. Early in the same season, it was found that the amount of money collected would not be sufficient for completing the construction of the hospital. Additional subscriptions of more than \$60,000 were obtained and the work went on. In May, 1867, the Rhode Island Hospital Trust Company was incorporated, "to create what should be a financial institution of high credit and powerful resources, and at the same time prove a pecuniary helper to the Rhode Island Hospital." The Trust Company was incorporated with five hundred shares of \$1000 each. Section 10 of the Charter stated, "Said Corporation is hereby empowered and required to pay over annually to the Rhode Island Hospital for its use, one third part of all the net annual profit upon the capital stock of said corporation over and above 6% thereon."

At the opening exercises at the Rhode Island Hospital, on October 1, 1868, Usher Parsons occupied a seat on the platform and was referred to by the President in his address as "our venerable friend, who today beholds the full accomplishment of all his benevolent aims." Yet his plan could not justly be said to be fully accomplished. The administration building and the south wing of the hospital were completed but the north wing was unfinished and there were no available funds for this purpose.

The Rhode Island Medical Society and the Providence Medical Association had offered to the hospital the free service of any of their members. George L. Collins, Charles W. Parsons, J. W. C. Ely, and Stephen S. Keene were appointed visiting physicians. G. E. Mason, E. T. Caswell, Robert Millar, and George W. Carr were appointed as visiting surgeons. Usher Parsons received an appointment on the consulting staff. Horace G. Miller, then the sole specialist in the city, headed the eye and ear department. The first house surgeon, R. C. Greenleaf, was followed by Albert E. Ham, H. C. Bullard, and Eugene Kingman. It is interesting to note that while Dr. Horace Miller was absent in Europe in the second year of the hospital's existence, the eye and ear service was successfully conducted by Dr. Kingman.

Usher Parsons donated his medical library to the Hospital. The libraries of Ezekiel Fowler, Nathaniel Miller, J. Davis Jones, and other local physicians soon brought the number of volumes in the hospital library to more than 2000. The library was a favorite spot for medical meetings and for consultations.

The first operation was performed by the senior surgeon, Dr. G. E. Mason, on October 10, 1868. The patient, John Sutherland, age 59, had entered the hospital on October 6, with the diagnosis, "Necrosis of the Jaw." In the presence of many of the staff, Dr. Mason did an extensive operation through two incisions, removing the wall of the antrum and extirpating a gelatinous cancerous mass which filled the antrum. The patient was etherized while sitting in a chair. He recovered without complication and was discharged from the hospital on December 7, improved. Usher Parsons was present at this operation but was taken sick a few days later and died on December 19, at the age of eighty years and four months.

Soon the staff was petitioning the Board of Trustees for completion of the north wing. This was done in 1874, fortunately. One morning in 1876, fire broke out in the drying room in the lower ward of the south wing, swept up the ventilating shaft to the attic and attacked the floor and the floor timbers. The fire was extinguished by the fire apparatus of the hospital with assistance from the city fire department but not before extensive damage had been done. The patients were quickly removed from the south wing to the north pavilion. The cost of repairing the damage was covered by that insurance policy which later was found to cover loss from hurricane.

In the year 1879, a trained nurse was first employed in the women's department, the City of Providence first provided ambulance service, and the hospital was connected with the city sewers by a twelve inch brick sewer which has never since become clogged.

In 1882 a Department of Gynecology was opened under the direction of Dr. George W. Porter and one of the rooms on the first floor assigned to this work. Here was installed the heavy wooden table for treatment in the Sims position which was in use for many following years. Two years later the Gynecological cottage, sacrilegiously dubbed "The Hut," was put up in the rear of the administration building. It was designed for performance of ovariectomy and other abdominal operations. The purpose was to avoid the danger from septic germs which thrived in the wards of the hospital. The cottage was isolated as perfectly as possible. It was placed at some distance from the hospital and was supported by posts several feet above the ground. The first operation in the Hut of which I have

found a record was done on February 9, 1885. The patient was Julia Lahey. She had a large ovarian cyst which had been under observation for some time. She was admitted to the hospital for the third time on February 3. The operation was done by Dr. George W. Porter. Present were Drs. Caswell, O'Leary, Mitchell, Ely, Noyes, Morgan, White, Godding, Terry, Hersey, and Whitford. The patient, fortified by regular doses of whiskey, was taken to the hut early in the morning. Ether was administered at 11:15. The contents of the cyst were aspirated with a trocar and the ovary removed. The abdominal cavity was sponged out with carbolyzed sponges and the wound was closed with silver wire. The operation lasted for an hour and a half. This was the time when the spray of carbolic acid was used to prevent spread of infection through the air of operating rooms. After Dr. Charles V. Chapin had proved that air borne infection could be disregarded, the Hut was abandoned and the Gynecological service was given the small room to the north of the main operating room for its work.

In the early years few changes were made in the original plans of the hospital. A visitor fifty years ago could have been shown, beside the main building with the north and south wings, only the keeper's house at the Eddy Street entrance, a cottage occupied by nurses, the boiler room and laundry, and the morgue. Passing under the imposing portico and through the main entrance, he would have found the apothecary shop on the right and the superintendent's office on the left. He would next have been impressed by the vista of long corridors reaching to the north and south wings. Crossing this corridor he would have entered the kitchen, where a hidden stairway descended to the store room and larder.

Along the main corridor to the north wing, one passed a cross corridor, leading on the right to the out-patient department and on the left to the accident room. The rooms in the north wing housed female servants. The rooms in the south wing were occupied by internes and male attendants. Along the main corridor leading to these rooms, one passed by the staff room and, beyond the cross corridor of the south wing, the interne's dining room on the left and the sewing room on the right.

On the second floor, the lofty room over the kitchen was called the chapel and was used as library, lecture hall and the place for staff meetings. The seats were long wooden settees. Once a

year these were moved into the hall and space made for the examination, conducted by a committee of the staff, of candidates for interne's positions. On the top floor of the administration building, directly over the chapel, was the operating room, with a lofty, domed ceiling, from which depended at the end of a long length of piping the gas chandelier by which the room was lighted at night. On the west the room was lighted by a large bay window. Opposite this, set high in the wall, was a gallery for spectators. In the anteroom which led to this gallery was installed the first X-ray machine which the hospital possessed. In the northeast corner of the operating room were the sterilizers. The operating table was located in the center of the room, under the chandelier. On either side were crescent-shaped wooden tables which served a double purpose; to support instruments, ligatures and dressings, and to keep visitors at a proper distance from the field of operation. To the south of the operating room was an etherizing room furnished with a cot, on the top of which was laid a canvas stretcher for more readily removing the etherized patient to the operating room. Ether was administered with a closed cone made from a butcher's cuff, covered with oiled silk and filled with sea sponge. When the word was given, two strong orderlies held the patient down on the stretcher and the interne went ahead. To the north of the operating room was a small room, once the recovery room, but after the Hut was abandoned, given over to the Department of Gynecology.

To the east, opposite the operating room, was a large room, once used as the staff library but later for male surgical patients, and designated as Ward E. This cheerful and sunny room was filled with patients under treatment for fractured bones and other such clean, quiet cases.

In either of the wings, one ascended to the upper floors by the wide stairways of stone, fireproof, so carefully designated in the original plan of the hospital. In the south wing, Ward D, on the second floor, was a male surgical ward, and Ward C, on the third floor, was taken up by male medical cases. One with sufficient courage could go up another story to the D. T. Ward, located in the south garret and the scene of some desperate encounters with maniacal patients. Having come so far, he might then climb to the south tower and above the great water tank enjoy from that vantage point a view of the river and of the city.

Wards A and B, in the north wing, were women's wards. The children's department was located in the west rooms of the second floor of this wing. The garret of this wing was used for storage.

While many of the internes climbed the south tower, few tried the north tower. The ladders were not securely fastened and word was passed along from year to year that the ascent was too dangerous to be worth while.

One who is over enthusiastic on the subject of modern progress may well contemplate the work of the founders of the Rhode Island Hospital. If these original buildings should be destroyed they could not be replaced today at any cost. After seventy years use the heating and ventilating systems work as perfectly as ever, the stairways of stone, fire-proof, show no signs of wear. In sixty years the bill for repairs on the outside of the buildings amounted to eleven dollars. Nurses who are familiar with the hospital testify that the original wards are more comfortable, more convenient, better ventilated, in fact, better suited for their work than are the buildings that have since been constructed.

GOVERNMENT TO NEED TEMPORARY AND PART-TIME CIVILIAN MEDICAL OFFICERS

The expansion of the army creates a need for about 600 civilian medical officers in various grades for temporary and part-time service. The duties of full-time officers will be to act as doctors of medicine in active practice in hospitals, in dispensaries, and in the field. The duty of part-time officers will be to report for sick call at a fixed hour each day and to be subject to emergency call at all times.

The Civil Service Commission in making this announcement calls particular attention to the fact that part-time officers will be able to continue their regular practice. In order that this may be done, appointments to the part-time positions will be made of medical officers in the vicinity of the place of duty.

Information concerning these positions may be obtained from the Secretary of the Board of U. S. Civil Service Examiners at any first- or second-class post office, or from the United States Civil Service Commission, Washington, D. C. Physicians are urged to apply at once. This work is of the greatest importance to the success of the National Defense program.



THE RHODE ISLAND MEDICAL JOURNAL

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EIGHTH ANNUAL CLINIC DAY AT MEMORIAL HOSPITAL

The Annual Interne Alumni Clinic Day at the Memorial Hospital in Pawtucket has become an occasion memorable among gatherings of Rhode Island physicians. While this hospital is not a large institution, enthusiastic cooperation of members of its staff in their different departments has produced an Annual Clinic Day which without doubt is the largest attended single clinic held in the State. This year the Clinic Day will be held on Wednesday, November 6th. Beside the clinics given by members of the staff, an outstanding group from the Memorial Hospital, New York City, will present the very latest information on the subject of "Malignancy," covering the entire body. The list of men and of subjects is as follows:—

"The Diagnosis and Treatment of Cancer of the Head and Neck." Hayes E. Martin, M.D.
 "The Diagnosis and Treatment of Cancer of the Breast." Norman Treves, M.D.

"The Diagnosis and Treatment of Cancer of the Gastrointestinal Tract." George T. Pack, M.D.

Before the 1st of November, each physician in Rhode Island will receive a list of the clinics and an invitation to attend them. The date is November 6, 1940.

INCREASED DEATH RATE FOR 1939

A slight rise in the United States death rate last year, as compared with 1938, is reported by the United States Bureau of Commerce in a preliminary tabulation for 1939. A total of 1,387,797 deaths last year resulted in a mortality rate of 10.7 deaths per 1000 estimated population. In 1938, there were 1,381,391 deaths and the death rate was 10.6. The death rates for 1938 and 1939 were the lowest rates, with the exception of 1933, reported since the death registration area was established in 1900.

Rhode Island, with a death rate of 11.4 per 1000 in 1939, showed a satisfactory improvement over the rate of 12.2 in 1938. Arizona, with a preliminary rate of 14.2 deaths per 1000, had the highest rate in the Nation. North Dakota had the lowest rate with 7.7 deaths per 1000.

An increase in the death rate, however, without allowance for other factors, is no indication of a failure in medical progress; no more is a decrease in death rate a source of satisfaction unless the same factors are considered. Over a term of years, with allowance for shifting of population through change of residence, the death rate must equal the birth rate. Effective medical treatment and improved sanitation prolong the average span of life but cannot permanently influence the annual death rate.

Increase in longevity is the present goal of effort of the medical profession. For this aim, estimation of state or national death rate, without consideration of birth rate and the other factors, is inconsequential; it is interesting but unimportant. Do not avoid the route through Arizona because of the state's high death rate nor decide upon North Dakota for a health resort because it has the lowest rate of any state.

But in a hospital, the death rate is the most certain element in determination of the standard of its medical and surgical work. Here a definite number of patients enter during the year; a definite number are discharged improved or cured; there is a definite

number of deaths. During the past few years there have been many rapidly adopted improvements in treatment which should have resulted in evident lowering of hospital mortality rates; such are the use of sulfanilamide, of sulfapyridine, of duodenal drainage, of intravenous fluids. Statistics from five representative New England general hospitals show that this has happened. During the past four years the average death rate in these five institutions has declined from 6.7 per cent to 4.3 per cent, an improvement in results of thirty-seven per cent. In one of these hospitals the death rate fell from 9.6 per cent to 3.5 per cent in the four year period. Two of the five hospitals report a mortality rate of less than three per cent. The figures are more remarkable if we remember that not so many years ago a general hospital, not in New England, reported a death rate of more than twenty per cent.

The Journal A. M. A., 109:9, 701-702, 1937; 111:9, 845-846, 1938; 113:9, 851-852, 1939; 115:9, 774-775, 1940.

RHODE ISLAND MEDICAL SOCIETY

Minutes of the One Hundred and Twenty-ninth Annual Sessions

Continued from Page 159

Report of the Committee on the Library

The work of the Library has increased during the past year, as has been the case for the last several years.

2,005 persons have visited the Library, and of these at least one-half requested reference work. In addition to this, there has been much reference work done via the telephone—i.e., requests for definitions of words, spellings, historical dates, etc.—requests that could be answered immediately. It becomes evident that the Library is serving the community more and more as a clearing house for all questions regarding medical matters and allied topics.

There have been received through purchase, gift and exchange a total of 126 Journals.

Accessions:

Purchase from Library Funds	22 volumes
Gifts and volumes sent to the Rhode Island Medical Journal, for review	425 volumes
Journals bound	102 volumes
Journals bound and repaired	5 volumes
	<hr/> 107

Of the gifts, the most notable were:

From Jesse E. Mowry, M.D.	75 volumes
Estate Byron U. Richards, M.D.	14 volumes and unbound pamphlets.
Estate Frederick N. Blair, M.D.	102 volumes
Estate Vito L. Raia, M.D.	171 volumes and unbound pamphlets.

The list of Journals at the Library is a very complete coverage of the field of medicine and surgery, and the specialties, and the effort is made to serve the demands of all the Fellows. During the past year the following Journals have been added to the subscriptions:

American Journal of Cancer
Canadian Medical Journal
Human Fertility.

18,464 books and journals have been catalogued to date.

Inter-library loan requests: The Boston Medical Library, the New York Academy of Medicine and the Army Medical Library have been very willing to send us books for the use of the Fellows.

Respectfully submitted,

HERBERT G. PARTRIDGE, *Chairman*

Report of the Committee on State Policies of Public Health

Requests were received from the Department of Civil Service of the State of Rhode Island for advice concerning the appointments of physicians to various departments of the State Hospitals and Schools under the civil service regulations.

As the regulations now stand they require that appointments be made from amongst those who are citizens of the State of Rhode Island.

It was urged by the Committee that in the event that no properly qualified persons were available for the various positions in the State Hospitals or Schools that the appointments be not necessarily confined to those who are citizens of the State.

Also at the request of the Department of Civil Service, a list of names of properly qualified physicians was submitted to the Department from which list physicians could be selected to serve on the special examining panels.

The Committee has been pleased with the wish of the Department of Civil Service to cooperate with the Rhode Island Medical Society.

Respectfully submitted,

FREDERIC V. HUSSEY, M.D.,
Chairman.

Report of the Committee on Maternal Mortality

The Committee on Maternal Mortality submits its report as follows:

Due to the reorganization in the State Bureau of Vital Statistics, there was an unavoidable delay in submitting to your committee the death certificates of the patients included in this report, so that no work could be undertaken in the first half of the year 1939, and the report was not concluded until March 1940.

SUMMARY OF MATERNAL DEATHS FOR 1939

Forty cases of death associated with pregnancy were investigated during 1939. Thirty-four of these died of puerperal causes and six died of non-obstetrical causes. A table showing the number under each rubric of the International Causes of Death follows:

140 Abortion with septic conditions.....	2
141 Abortion without septic conditions to include hemorrhage	3
142b Ectopic pregnancy without septic condition	1
144a Placenta Previa	2
144b Other puerperal hemorrhages	3
145a Puerperal septicemia (not due to abortion)	7
146 Puerperal albuminuria and eclampsia	6
147 Other toxemias of pregnancy	3
148 Puerperal phlegmasia alba dolens, embolus, sudden death	1
149 Accidents of pregnancy:	
a. Cesarean section	5
b. Other under this title	1
Non Obstetrical Causes	6
Total	40

140 Abortion with septic conditions

Under this rubric there were two cases, both of which were septic on admission, and both of which were suspected of having been induced. Both were hospitalized, and treatment was apparently adequate. The second had a D & C after a severe hemorrhage in the hospital. The temperature fell only to rise again.

141 Abortion without septic conditions to include hemorrhage

All three cases were spontaneous. Two of these were bleeding actively on admission. The first case was under treatment by her own physician at home for two days. Admitted in poor condition, bleeding

profusely, and plans were made for a D & C in the morning. Went into shock, no transfusion given, died in shock.

CASE NO. 2. Had been bleeding three weeks on the outside and was admitted to the hospital with active bleeding. Three hours later she was given a blood transfusion. This was followed by a reaction after a small amount of the blood had been given. Death five hours later. There is a question as to how much the transfusion reaction contributed to death.

CASE NO. 3. Had spontaneous rupture of membranes at four and one-half months of pregnancy. Eventually she was delivered at 5½ months of twins. Patient continued to bleed. Hysterectomy was done, but even this did not control the bleeding. Death from hemorrhage.

142b Ectopic pregnancy without septic conditions

This patient was seen in the O.P.D. where the diagnosis of Ectopic Pregnancy was missed. Manipulation apparently ruptured the ectopic and patient went into shock. No operation; the diagnosis was made at autopsy.

144a Placenta Previa

There were two cases in which death was attributed to Placenta Previa. No. 1 was a primipara in which the diagnosis was made and laparotrachelotomy done. Developed thrombosis of the left leg twelve hours after operation. Died three days later. At autopsy no free fluid or evidence of septic peritonitis was found. Patient died of thrombosis, the cause was unknown. In the second case, the physician was called because the family thought that the patient was bleeding in active labor, having painless contractions, and rectal examination showed what was considered to be placenta in the front of the head. Physician returned ½ hour later to find the patient dead. Adequate information could not be obtained to make proper classification in this case. One other case of Placenta Previa was signed out as due to Sepsis. This was a partial placenta previa treated by bagging. This was followed by hemorrhage. Eventually there was a hysterectomy. Sepsis followed causing death.

144b Other puerperal hemorrhages

There were three cases under this heading. All were operative deliveries in hospitals. Two died shortly after delivery. There was no reason to believe that operative technique was not satisfactory and both received adequate treatment. One was a case of ante, intra, and post partum bleeding,

the other a case of post partum bleeding. A third case was operative, with adequate technique which required packing because of immediate post partum bleeding. Massive bleeding recurred on the 6th day resulting in death before supportive measures could be established.

145a Puerperal septicemia (not due to abortion)

There were seven cases of puerperal sepsis. Five of these followed operation and may be listed as follows:

1. High forceps after bagging to induce labor.
2. Version and extraction — septic — transfused. Died 3½ hours later, probably due to transfusion reaction.
3. Spontaneous onset of labor at home. Non-engagement. Sent to hospital, Porro section done. Septic. Died shortly after secondary operation for exploration of abdomen and pelvic abscess.
4. Pregnancy not suspected. Laparotomy done for fibroids. Spontaneous delivery. The peritonitis in this case was not puerperal but was post-operative.
5. Bagging and hysterectomy. This is discussed under placenta previa.

There were two cases in which the delivery was spontaneous. In one case acute mastitis occurred 17 days after delivery. Patient was apparently septic, but that the origin was puerperal was not proven. Another patient was delivered at home, spontaneously, became septic, and was admitted to a general hospital. Here mental symptoms developed and was transferred to a mental hospital where she died. This was a case of bilateral thrombophlebitis and terminal nephritis.

146 Puerperal albuminuria and eclampsia

There were six cases of eclampsia. Only one of these had even suggestively adequate prenatal care and at that the patient did not follow the advice of the physician. Two were admitted in convulsions. All others were admitted as pre-eclamptics who had convulsions shortly after admission. Two died undelivered. In one case an operative procedure resulting in rupture of the uterus probably contributed to death.

147 Other toxemias of pregnancy

There were three cases of pernicious vomiting. All were hospitalized and received a good trial of medical treatment while there. In no case was pregnancy interrupted. One patient aborted spontaneously after 20 days of hospital care and died 10 days later.

148 *Puerperal phlegmasia alba dolens, embolus, sudden death*

One patient died suddenly on the 11 day post-partum after an uneventful puerperium. This patient was delivered by Mid forceps.

149a *Accidents of pregnancy. Cesarean section*

Death was attributed directly to Cesarean section in five cases. Other cases which died following section are considered in other classifications and will be discussed later.

There were two low flap sections and two classical sections. One low flap section died of phlebitis and pulmonary embolism. The operation was done for a justo-minor pelvis. Another of this type died 5 days post-operative of abdominal distention and acute cardiac decompensation. The indication was a myomectomy at the third month.

One patient died after a classical section in which the indication was not learned. This case had a 12 hour labor. She died of pulmonary embolism following thrombo-phlebitis. Another was a neglected case which had been in labor 3 days at home under the care of a mid-wife. On admission to the hospital the mother was in shock and section was done to save the baby. The mother died in shock.

One woman had been given Pontocain intraspinally for anaesthesia preparatory to a section. This patient died after the spinal had been given but before the operation had started. A post-mortem section was done.

Three other cases were reported elsewhere as the result of Cesarean Section, via., 144a—1; 144b—2. 24% of the total number of deaths and 29% of the deaths of this series occurring after the 5th month of pregnancy followed Cesarean Section.

149b *Accidents of pregnancy. Others under this title.*

One luetic patient with pre-eclamptic toxemia, an old hypertensive, was given a medical induction. She was delivered spontaneously after a five hour labor. She went into shock and was found to have a ruptured uterus. Death occurred while supportive treatment was being given.

Non-Obstetrical causes of death

Six cases of pregnancy died of non-obstetrical causes. Of the 4 cases which were cardiacs, two died at term, one in the 7th month, and one in the 8th month. Two were delivered and two were undelivered.

One patient died undelivered in diabetic acidosis. One patient died of general peritonitis following perforated appendix. This patient had a Mid forceps delivery of a stillborn child.

Prenatal Care

Prenatal care of the patient's studied has been classified as follows:

Class I — is good prenatal care. It consisted in the patient reporting to the physician in the second month. A general medical and obstetrical examination and later regular office visits at which blood pressure readings and urinalysis were done.

Class II — This care was classified as fair. It began not later than 7th month and the same amount of diagnostic and follow up work was done as in the previous class.

Class III — was poor care. This at times began in the early months but was not constant, or else, it may have consisted in only one visit. Some patients had no prenatal care.

In others a classification of prenatal care is not applicable.

Those cases dying of abortion, ectopic gestation, and those with pernicious vomiting of pregnancy are not classified.

A table showing the distribution of prenatal care as follows:

	<i>Puerperal Deaths</i>	<i>Non-Obstetrical</i>	<i>Total</i>
Class I	12	3	15
Class II	4	0	4
Class III	6	1	7
None	3	2	5
Not Applicable	9	0	9
Total	34	6	40

Your chairman believes that the work of this committee should be continued. At the present time, no further death certificates are being received from the Dept. of Vital Statistics, because the Census Department Bureau in Washington plans to provide a new international classification of diseases. When such a new list is available, our committee with the cooperation of the Department of Child and Maternal Welfare of the State Department of Health will continue further study of maternal mortality in Rhode Island.

Respectfully submitted,

JOHN G. WALSH, M.D.,
Chairman.

Report of the Resolutions Committee

No Resolutions were brought before the Committee, therefore, no report.

Respectfully submitted,

HERBERT E. HARRIS, M.D.,
Chairman.

HOSPITALIZATION UNDER WARD PLAN BY HOSPITALS

All Cases Discharged Through February 29, 1940

Type of Accommodations used	Occupation of applicant	Diagnosis	Days Stay
HOMEOPATHIC HOSPITAL			
1. Semi-Private	Hospital Employee	Int. Grippe	8
2. Semi-Private	Hospital Employee	Cold	14
3. Semi-Private	Office Worker	Tooth Extraction	2
4. Ward	Hospital Employee (8 mos. son)	Observation	8
NEWPORT HOSPITAL			
1. Semi-Private	Printer (Wife)	Appendicitis	10
MEMORIAL HOSPITAL			
1. Ward	Hospital Employee (Maid)	Renal Calculus	3
2. Ward	Jigger Mill Hand	Appendicitis	12
RHODE ISLAND HOSPITAL			
1. Ward	Seamstress (74 yrs. old)	Shock	21
2. Private	Nurse	Appendicitis	11
ST. JOSEPH'S HOSPITAL			
1. Ward	Side Seamer (Mill Hand)	Appendicitis	14
2. Semi-Private	Stenographer	Pan Hysterectomy	18
3. Ward	Pumpman (5 children) 10 yr. d.	Appendicitis	15
WESTERLY HOSPITAL			
1. Ward	Retired	Melena	21
2. Ward	Hospital Employee	Enteritis	11
3. Private	Carpenter (6 yr. old son)	Tonsillectomy	1
4. Ward	Office Worker	Duodenal Ulcer	13
BUTLER HOSPITAL			
1. Infirmary	Hospital Employee	Myositis L. Thigh	8
2. Infirmary	Hospital Employee	Pharyngitis	5
3. Infirmary	Hospital Employee	Influenza	6
TRUESDALE HOSPITAL			
1. Private	Janitor	Angina Pectoris (Dec.)	4
SUMMARY OF CASES		BLUE CROSS ENROLLMENT TO MARCH 1, 1940	
1. Ward	9	Semi-Private Plan	9,416 — 77.2%
2. Semi-Private	5	Ward Plan	2,774 — 22.8%
3. Private	3		
4. Infirmary	3		
Total Cases	20	Total Subscribers	12,190 — 100%

During the same period there were 114 Semi-Private Plan patients hospitalized; of this number 58 used Private room accommodations and 56 used Semi-Private room accommodations.

Report of the Hospitalization Insurance Committee

The Hospitalization Insurance Committee has not met since the last report was given by this Committee before the January Meeting of the House of Delegates.

The Chairman, however, met with a Committee representing the Providence Medical Society in early March. At this Meeting, Dr. Brackett was also in attendance. Briefly, the action taken at this

Meeting was a vote of confidence in the functioning of the Blue Cross, especially with respect to the Ward Plan. Statistics as of February 29, 1940 show clearly that members of the Plan are not taking any undue advantage of the Medical Practitioners, and that the plan is serving a good purpose. Eight of the twenty enrolled in the Ward Plan and hospitalized, became semi private and private patients, while three were infirmary Hospital Employees. In other words, only nine of the twenty remained Ward patients. Of the local en-

rollment March 1st, 22.8% were subscribers under the Ward Plan. There are now over 15,000 semi-private and ward subscribers enrolled under the Blue Cross.

A detailed statement of the twenty members hospitalized and enrolled under the Ward Plan is attached to this report. The Chairman would like to suggest that a similar statement brought up to date be published in the Rhode Island Medical Journal, with any other pertinent points of interest to the Medical Profession concerning the Blue Cross.

Respectfully submitted,
ELIHU S. WING, M.D.,
Chairman.

STATE DEPARTMENT OF HEALTH FREE DISTRIBUTION OF SULFAPYRIDINE

The attention of all Rhode Island physicians who are treating gonococcal infections is invited to a new phase in the venereal disease control program of the Rhode Island State Department of Health. Sulfapyridine tablets for the treatment of any reported case of gonorrhea are now being distributed by the Department without charge to any registered physician. The drug may be obtained at Room 370, State Office Building, or at any of the District Health Unit offices which are located in Woonsocket, Bristol and Peacedale. Sulfapyridine is being made available on the recommendation of the American Neisserian Medical Society and the U. S. Public Health Service. An increased financial grant under provisions of the Federal Venereal Disease Control Act makes possible the local distribution by the State Department of Health. After more than two years of study of a large number of patients being treated for gonococcal infections, the American Neisserian Medical Society and the U. S. Public Health Service prepared sets of suggestions for the management of gonorrhea in the male and in the female. Copies of these recommendations have been mimeographed and are available at the offices of the State Department of Health.

The Department's policy of the free distribution of antisypilitic drugs remains unchanged. Arsenicals and Bismuth preparations are freely available to any registered physician for the treatment of a reported case.

NEW ENGLAND POSTGRADUATE ASSEMBLY SANDERS THEATRE, HARVARD UNIVERSITY, CAMBRIDGE, MASS. NOVEMBER 13-14, 1940

PROGRAM

WEDNESDAY, NOVEMBER 13

Morning Session

- 9:50 Assembly called to order by Dr. Frank R. Ober, Chairman, Executive Committee.
- 10:00 "The Practitioner and the Problems of Diabetes." Dr. Robert F. Loeb.
- 10:30 "Factors in the Production of Anemia." Dr. Russell L. Haden.

Intermission

- 11:15 "Treatment of Injuries of the Hand." Dr. Sumner L. Koch.
- 11:45 "The Medical and Surgical Management of Diverticulitis of the Colon." Dr. Henry W. Cave.
- 12:15 Luncheon (Memorial Hall).

Afternoon Session

- 2:00 "The Causes of Indigestion and Their Recognition." Dr. T. Grier Miller.
- 2:30 "Fungous Infections of the Skin." Dr. Oliver S. Ormsby.
- 3:00 "The Urinary Bladder in Health and Disease." Dr. Percy S. Pelouze.

Intermission

- 3:45 "The Management of Pre-eclampsia in Private Patients." Dr. Fred L. Adair.
- 4:15 "The Treatment of Respiratory Depression." Dr. Ralph M. Waters.
- 4:45 "Diagnosis and Treatment of Cancer of the Colon." Dr. Henry W. Cave.
- 6:30 Concert (Memorial Hall).
- 7:00 Dinner (Memorial Hall). Toastmaster, Dr. Reginald Fitz. Speaker, Dr. Harrison S. Martland, Newark, New Jersey — "Dr. Watson and Mr. Sherlock Holmes."

THURSDAY, NOVEMBER 14

Morning Session

- 9:00 "How May the General Practitioner Diagnose Cancer of the Cervix?" Dr. Fred L. Adair.
- 9:30 "The Relation of Anesthesia to Infant Morbidity." Dr. Ralph M. Waters.
- 10:00 "The Examination of the Nervous System." Dr. Tracy J. Putnam.
- 10:30 "Present-Day Concepts of the Management of Ulcerative Colitis." Dr. Henry W. Cave.

Intermission

- 11:15 "Precancerous Dermatoses." Dr. Oliver S. Ormsby.
- 11:45 "The Mechanism and Management of Diabetic Acidosis." Dr. Robert F. Loeb.
- 12:15 Luncheon (Memorial Hall). To be followed by a question period.

Afternoon Session

- 2:00 "Treatment of Acute Infections of the Hand." Dr. Sumner L. Koch.
- 2:30 "The Diagnosis and Treatment of the Convulsive State." Dr. Tracy J. Putnam.
- 3:00 "Present-Day Therapy of Gonococcal Infections." Dr. Percy S. Pelouze.

Intermission

- 3:45 "The Use of Liver and Iron in the Treatment of Anemia." Dr. Russell L. Haden.
- 4:15 "The Management of the Complications of Peptic Ulcer." Dr. T. Grier Miller.

RECENT BOOKS

SIMPLIFIED DIABETIC MANUAL. By Abraham Rudy, M.D., pp. 216, Cloth, \$2.00. M. Barrows & Company, Inc., 286 Fifth Avenue, New York, 1940.

While there are many diabetic manuals on the market for the use of patients, it is readily asserted that there is room for one more.

Dr. Rudy has attempted to overcome the failings of some of the other volumes by including a large number of recipes, particularly those for people of foreign nationality. A fairly complete list of food values is also included.

In the main portion of the volume, the author attempts to give a brief treatise on the subject of diabetes, which the reviewer feels is too complete and technical for a book for the laity, and too superficial for a member of the profession.

The pages devoted to testing the urine, and administering insulin, are quite good on the whole. There are some debatable techniques recommended. A color chart is included to show the changes in the Benedict's solution, but, as is often the case, the color rendition is inadequate. The illustration of the syringes employed is out of date, in not being marked with units, but in tenths of a cc. The author also fails to direct the patient to inject air into the insulin bottle before withdrawing the fluid.

As a diabetic manual it is the reviewer's feeling that this book fails. As a list of diet and food values, it has a place.

FRANCIS H. CHAFEE, M.D.

THE MANAGEMENT OF OBSTETRICAL DIFFICULTIES. By Paul Titus, M. D. pp. 968, with 368 illustrations and 5 color plates. Second Edition. Cloth, \$10.00. The C. V. Mosby Company, St. Louis, 1940.

Three years ago the excellent book, "The Management of Obstetric Difficulties," was first published by Dr. Paul Titus of Pittsburgh. The aim of this original work was to offer a practical aid to all physicians who meet and contend with obstetric difficulties and emergencies. It was designed as a reference book not only for the obstetrical specialist but also for the general practitioner, to offer readily available means not only of recognizing impending obstetric trouble but also of more adequately coping with the given situation. Dr. Titus appreciates that the greater part of obstetric practice in this country is done by the general practitioner—certainly that he is so often the first to see the complicated cases. In this book he has chosen to cover mainly the abnormal phases of obstetrics, leaving the normal obstetrics to general textbooks on the subject. He has apparently hoped to offer the obstetric specialist a very high grade reference book and at the same time to make available for the general practitioner a book of very practical value—to help make him more emergency conscious and better prepared to meet the complication at hand until more skilled help is available. This purpose Dr. Titus has excellently fulfilled.

The second edition has been revised and many new things have been included—recent advances in the treatment of sterility, the use of sulfanilamide in puerperal sepsis and pyelitis, the detailed technic of x-ray pelvimetry, technical advances in various operative procedures, in the management of toxemia and of the anemias of pregnancy, and improvements in obstetrical analgesia and anesthesia. Many deletions have been made, chiefly of subject matter formerly, or even still, controversial. The book is slightly more of a textbook than the first edition chiefly due to the additions to the bibliography. However it still differs from the usual textbook by limiting its subject matter to the practical aspects of minor and major obstetric emergencies, and their management.

The book is divided into eight sections. The first gives an excellent discussion of the causes and factors and treatment of sterility. Dr. Titus has an unusually high percent of relief of sterility in a series of sterility cases studied by him. The second section deals with difficulties in diagnosis of pregnancy. The third is devoted to the complications of pregnancy, the important obstetrical, medical, and surgical complications. This includes the management of ectopic pregnancy, placenta previa and premature separation of the normally implanted placenta, the anemias and the toxemias of pregnancy. Each subject is brought down to include the latest accepted work in treatment and technic. Section four covers complications of labor and includes the detailed technic of x-ray pelvimetry. The remaining sections include obstetric operations, complications of the puerperium, accidents and birth injuries of the newborn including asphyxia neonatorum and its treatment. The final section discusses antepartum, postpartum, postoperative care of the patient, and newer ideas on obstetrical analgesia and anesthesia.

The book is very clearly illustrated throughout and the illustrations follow the text very closely. Dr. Titus has considered the complications, emergencies, and difficulties of obstetrics in such detail to make this book an excellent reference guide for all who do obstetric work.

JARVIS D. CASE, M.D.

SYNOPSIS OF OBSTETRICS. By Jennings C. Litzenberg, M.D., F. A. C. S. pp. 394, with 157 illustrations including 5 in color. Cloth, \$4.50, The C. V. Mosby Company, St. Louis, 1940.

Dr. Litzenberg, who has been one of the leading teachers of obstetrics in this country for many years, presents the subject of obstetrics in outline form. His aim, he states in the preface, has been to minimize less essential details and emphasize the more important. The general tenor of the text is conservative. The important details of obstetrics have been condensed and arranged in brief concise sentences. The illustrations, most of which have been borrowed from textbooks and medical periodicals, have been selected because of their superior value. For such a brief volume this text is surprisingly complete and should prove an excellent aid not only to the general practitioner but to all students of obstetrics—particularly as a brief, yet adequate, review of the subject.

JARVIS D. CASE, M.D.